Dec 96
DoD 1400.25-M

Notice of Occupational Disease and Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): BROWN, Myron I.

2. Social Security Number: 300-10-2222

3. Date of birth: Mo. 3 Day 18 Yr. 40

4. Sex: M

5. Home telephone: (111) 555-4444

6. Grade as of date of last exposure: Level WG-10 Step 5

7. Employee's home mailing address (Include city, state, and ZIP code)
1234 Elm Street
San Antonio, TX 78253

8. Dependents
- [X] Wife, Husband
- [ ] Children under 18 y
- [ ] Other

Claim Information

9. Employee's occupation: Utility Systems Repairer

a. Occupation code: WG-4742

10. Location (address) where you worked when disease or illness occurred (Include city, state, and ZIP code)
CEAF
Lackland AFB, TX 78236-5554

11. Date you first became aware of disease or illness: Mo. 3 Day 10 Yr. 95

12. Date you first realized the disease or illness was caused or aggravated by your employment: Mo. 3 Day 10 Yr. 95

13. Explain the relationship to your employment, and why you came to this realization
May last hearing examination showed I had a significant loss of hearing in both ears. I am exposed to noisy equipment most of the day, five days a week. I have been exposed to this noise for 15 years. I think this caused my loss of hearing.

14. Nature of disease or illness: Hearing Loss - both ears

OWCP Use - NOI Code
b. Type code: 700
c. Source code: 0240

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for th delay.
N/A

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.
N/A - Statement is Attached

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.
N/A - Medical reports are attached.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Myron I. Brown Date 3-18-95

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensatic as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative reme as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Form CA-2
Rev. Sept. 1

Figure 810-8. CA-2 (Hearing Loss).

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

(2) Payment of compensation for total or partial wage loss.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

BROWN, Myron I.

I was first notified about this condition on (Mo., Day, Yr.)

March 18, 1995

At (Location)

CEAF
Lackland AFB, TX 78236-5554

Signature of Official Superior	Title	Date (Mo., Day, Yr.)
John C. Mills		March 22, 1995

This receipt should be retained by the employee as a record that notice was filed.

Form CA-2
Rev. Sept. 1993

Figure 810-8 Continued. CA-2 (Hearing Loss).

NSTRUCTIONS FOR COMPLETING FORM CA-2

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement o the form. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional vidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the date it started.

b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.

c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.

d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)

e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Dealed description of the physician's findings.

d) Results of x-rays, laboratory tests, etc.

e) Diagnosis.

f) Clinical course of treatment.

g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.

b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.

c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.

d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanations: Some of the items on the form which may require further clarification are explained below.

14. Nature of the disease or illness
Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

19. Agency name and address of reporting office
The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

20. Employee's duty station, street address and ZIP code
The street address and zip code of the establishment where the employee actually works.

23. Name and address of physician first providing medical care
The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

24. First date medical care received
The date of the first visit to the physician listed in item 23.

32. Was the injury caused by third party?
A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

Employing Agency - Required Codes

Box a (Occupational Code), Box b, (Type Code), Box c (Source Code), OSHA Site Code
The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code
This is a four digit (or four digit two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Figure 810-8 continued. CA-2

U.S. GOVERNMENT PRINTING OFFICE: 1993 - 361-997 - 415/99071

...Report of Occupational Disease. Please complete information requested below

Supervisor's Report

. Agency name and address of reporting office (include city, state, and ZIP Code)

394 MSSQ/MSCE

1821 Wilbur Wright Plaza

Lackland AFB, TX 78236-5554

OWCP Agency Code: 1000-ZZ

OSHA Site Code:

ZIP Code

). Employee's duty station (Street address and ZIP Code)

Same As Item 19

ZIP Code

. Regular work hours From: 7:30 ☒ a.m. ☐ p.m. To: 4:00 ☐ a.m. ☒ p.m.

22. Regular work schedule ☐ Sun. ☒ Mon. ☒ Tues. ☒ Wed. ☒ Thurs. ☒ Fri. ☐ Sat.

. Name and address of physician first providing medical care (include city, state, ZIP code)

A. B. Simpson, MD

4000 Oak Street

San Antonio, TX 78236

24. First date medical care received: Mo. 3 Day 10 Yr. 95

25. Do medical reports show employee is disabled for work? ☐ Yes ☒ No

. Date employee first reported condition to supervisor: Mo. 3 Day 18 Yr. 95

27. Date and hour employee stopped work: Mo. N/A Day Yr. Time : ☐ a.m. ☐ p.m.

. Date and hour employee's pay stopped: Mo. N/A Day Yr. Time : ☐ a.m. ☐ p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness: Mo. Day Yr. Continues in same duties and cautioned to wear protection devices over ears.

. Date returned to work: Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

. If employee has returned to work and work assignment has changed, describe new duties

Work assignment has not changed.

. Was injury caused by third party? ☐ Yes ☒ No If "No," go to Item 34.

33. Name and address of third party (include city, state, and ZIP code)

gnature of Supervisor

. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

John C. Mills

me of Supervisor (Type or print)

John C. Mills

nature of Supervisor

March 25, 1995

Date

Chief, AC Section

ervisor's Title

(111) 555-6666

Office phone

Figure 810-8 Continued. Form CA-2 (Hearing Loss).

Form CA-2
Rev. Sept. 1993

Notice of Occupational Disease and Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Dec 96
DoD 1400.25-M

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): DAVIS, Mary J.

2. Social Security Number: 002-22-0000

3. Date of birth: Mo. 4 Day 25 Yr. 52

4. Sex: F

5. Home telephone: (703)888-9696

6. Grade as of date of last exposure: Level 7 Step 7

7. Employee's home mailing address (Include city, state, and ZIP code)
1234 Jefferson Street, Apt A-3
Arlington, VA 22202

8. Dependents
- [X] Wife, Husband
- [ ] Children under 18
- [ ] Other

Claim Information

9. Employee's occupation: Computer Specialist

a. Occupation code

10. Location (address) where you worked when disease or illness occurred (Include city, state, and ZIP code): Pentagon, Washington, DC 22202-1155

11. Date you first became aware of disease or illness: Mo. 12 Day 1 Yr. 93

12. Date you first realized the disease or illness was caused or aggravated by your employment: Mo. 2 Day 15 Yr. 94

13. Explain the relationship to your employment, and why you came to this realization
My work requires approximately 5-6 hours of intermitter keyboarding per day and I've had this job for the past 5 years. I first noticed tingling and numbness of my hands in December 1993. I saw a doctor on 2-15-94 who diagnosed carpal tunnel syndrome.

14. Nature of disease or illness: Carpal Tunnel Syndrome

OWCP Use - NOI Code
b. Type code | c. Sourc

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason fo delay.
N/A

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.
N/A - Statement Attached

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.
N/A - Medical Attached

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Mary J. Davis. Date 2-15-94

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compens as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative r as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Form CA
Rev. Sep

Figure 810-9, CA-2, Occupation Disease - Sample Carpal Tunnel

Supervisor's Report

19. Agency name and address of reporting office (Include city, state, and ZIP Code)

Department of the Army

Personnel & Security

Room 3B347 - Pentagon, Washington, DC 20301-1155

ZIP Code

OWCP Agency Code: 0000

OSHA Site Code:

20. Employee's duty station (Street address and ZIP Code)

Pentagon

ZIP Code

21. Regular work hours From: 7:00 [X] a.m. [ ] p.m. To: 3:30 [ ] a.m. [X] p.m.

22. Regular work schedule [ ] Sun. [XX] Mon. [X] Tues. [X] Wed. [XX] Thurs. [X] Fri. [ ] Sa

23. Name and address of physician first providing medical care (include city, state, ZIP code)

Jack O. Smith, MD

200 Duke Street

Alexandria, VA 22302

24. First date medical care received: Mo. 2 Day 15 Yr 94

25. Do medical reports show employee is disabled for work? [X] Yes [ ] No

26. Date employee first reported condition to supervisor: Mo. 12 Day 1 Yr. 93

27. Date and hour employee stopped work: Mo. 2 Day 15 Yr. 94 Time 7:00 [X] a.m. [ ] p.m.

28. Date and hour employee's pay stopped: Mo. 3 Day 8 Yr. 94 Time 7:00 [X] a.m. [ ] p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness: Mo. 2 Day 15 Yr. 94

30. Date returned to work: Mo. Day Yr. Time : [ ] a.m. [ ] p.m. Has Not Yet Returned

31. If employee has returned to work and work assignment has changed, describe new duties

32. Was injury caused by third party? [ ] Yes [X] No If "No," go to Item 34.

33. Name and address of third party (include city, state, and ZIP code)

Signature of Supervisor

34. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Carol R. James

Name of Supervisor (Type or print)

Carol R. James

Signature of Supervisor

Date

Chief, Information Management Systems

Supervisor's Title

(703) 695-0000

Office phone

Form CA-2
Rev. Sept. 19

Figure 810-9. CA-2, Occupational Disease - "Sample Carpal Tunnel" continued

DCPMS INSTRUCTIONS FOR COMPLETING FORM CA-2, NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

The employee or the employee's representative fills out Items 1 through 18 as follows:
Item 1. Employee's last name, first name, middle name (enter NMN if no middle name.).
Item 2. Employee's social security number.
Item 3. Employee's date of birth (month, day, year) - NOT TODAY'S DATE OR CURRENT YEAR.
Item 4. Employee's gender.
Item 5. Employee's home telephone number with area code; if no home phone; enter "NONE."
Item 6. Grade and pay as of date of last exposure.
Item 7. Employee's complete home mailing address, including ZIP code.
Item 8. Employee marks the appropriate boxes - numbers are not required. If no dependents, enter "NONE."
Item 9. Employee's job title, employee's pay plan, and the four numbers of the occupational series as listed on the SF 50.
Item 10. Work location where disease or illness developed. Show complete address including 9-digit ZIP code if location is not the same as Item 8.
Item 11. The date that the employee first became aware of the disease or illness. (This may or may not be the same date that he or she realized that it was caused or aggravated by his or her employment.
Item 12. The date that employee realized the disease or illness was caused or aggravated by employment.
Item 13. The employee should be very specific.
Item 14. Description of the condition claimed to be work-related.
Item 15. If an entry is required, give a specific reason.
Item 16. If separate narrative on the disease is not submitted with this form, explain reason for delay.
Item 17. If required medical forms are not attached, explain reason for delay.
Item 18. Be sure the normal signature is used. This is the actual date the completed Form CA-2 is submitted to the supervisor.
NOTE: Be sure to instruct employee to furnish all information as required in the instructions. Failure to do so might delay adjudication of the claim.
The supervisor fills out Items 19 through 34. Supervisors:
Item 19. Enter complete address of the servicing CPO/HRO authorized to forward the Form CA-2 to the OWCP. This address may or may not be the same as that in Item 10. Use the appropriate numeric and alpha chargeback code.
Item 20. Enter the street address and 9-digit ZIP code of the establishment where the employee actually works.
Item 21. If the employee has a fixed schedule, enter beginning and ending times. If intermittent, enter "INTERMITTENT."
Item 22. If the employee has a fixed schedule, indicate the scheduled workdays. If the employee has a rotating schedule, enter "ROTATING."

Figure 810-10. Instructions for Completing Form CA-2.

Item 23. Enter the name and address of the physician who first provided care for the claimed work-related illness/disease.
Item 24. Obtain this data from the medical reports submitted by the employee, if available. If reports are not available, enter "UNKNOWN."
Item 25. Refer to the most current medical reports. Do not use verbal information received from the employee. If no medical reports are available, enter "NO REPORT AVAILABLE."
Item 26. Enter specific date you were first notified of physical condition being related to employment.
Item 27. If no disability has been caused, enter "HAS NOT STOPPED."
Item 28. If the employee did not stop work, enter "NA."

- If a period of disability was caused by the claimed illness/disease, enter the specific date and time the employee stopped work.
- If the employee was disabled due to the claimed illness/disease and entered into a LWOP status commencing after the exhaustion of the employee's sick and annual leave, enter the specific date and time the LWOP status started.
- If the employee was disabled due to the claimed illness/disease and used sick or annual leave throughout the period of disability, enter "NA, USED SICK OR ANNUAL LEAVE."
- If employee has been separated and will not return to work, give date of separation.

Item 29. Based on the condition identified as the cause of the illness/disease in the employee's statement, determine if a specific answer is possible.
Item 30. If employee did not stop work, enter "NA."

- If employee did stop work due to the claimed illness/disease:

(1) Enter the date and hour the employee returned to work following the disability period; or

(2) Enter "HAS NOT RETURNED" if disability continues beyond the date the Form CA-2 is submitted.

Item 31. Complete this item only if the employee returned to work following a period of disability and the work assignment has changed. If so, describe the new duties and indicate if the assignment is a light-duty assignment. If the work assignment has been changed to accommodate the claimed illness/disease without a period of disability, so indicate.
Item 32. Self-explanatory.
Item 33. Self-explanatory.
Item 34. If you take exception to any information furnished by the employee in Items 1 through 18, identify the items and explain the reasons. Use an attachment if necessary. If not, enter "NA."
NOTES: 1. Be sure to include statement commenting on employee's narrative statement as required by instructions.
2. Complete the Receipt of Illness/disease portion and promptly give it to the employee.

Figure 810-10 Continued. Instructions for Completing Form CA-2.

DoD 1400.25-M Dec. 96

Federal Employee's Notice of Recurrence of Disability and Claim for Continuation Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0
Expires: 07-31-

Employee: Please complete Part A below.
Employing Agency (Supervisor or Compensation Specialist): Complete Part B.

Employee Data Part A - Employee

1. Name of employee (Last, First, Middle)	2. Social Security Number	3. OWCP file number for origi injury (if known)
JONES, John E.	999-66-3958	A00-111112

4. Date of birth Mo. Day Yr.	5. Sex	6. Home telephone
6 12 57	[X] Male [ ] Female	(333) 444-9898

7. Employee's home mailing address (include city, state, and zip code)
318 Pine Street
Richmond, VA 23297

8. Dependents
[X] Wife, Husband
[ ] Children under 18 years
[ ] Other

9. Name and Address of Employing Establishment at time of original injury (number, street, city, state, zip code)
Naval Weapons Station
Code 0641
Yorktown, VA 23691

10. Name and Address of Employing Establishment at time of recurrence, if other than 9. If you are no longer employed with the Federal Government, complete Part C in addition to Part A.
Same As Item 9

11. Date and Hour of original injury (mo., day, year)	12. Date and Hour of recurrence (mo., day, year)	13. Date and Hour stopped work following recurrence (mo., day, year)	14. Date and Hour pay stopped following recurrence (mo., day, year)	15. Date and Hour returned to work (mo., day, year)
[ ] a.m. [X] p.m. 11-5-94 1:30	[X] a.m. [ ] p.m. 2-3-95 10:15	[X] a.m. [X] p.m. 2-3-95 10:15	[ ] a.m. [ ] p.m. Not Yet	[ ] a.m. [ ] p.m. Not Yet

16. Dates of medical treatment following recurrence (mo., day, year)	17. Name and Address of physician treating employee following recurrence
2-3-95	A. C. Jones, M.D. 1098 Smith Road Richmond, VA 23297

18. After returning to work following the original injury, were you handicapped or in any way limited in performing your usual duties? (If yes, explain) [X] Yes [ ] No
Limited to lifting no more than 20 lbs. -- usual duties require 40 lbs.

19. Describe fully your condition since you returned to work including all medical treatment received.
Continued to have moderate back pain -- participated in therapy program and did back strengthening exercises at home.

20. Describe the circumstances of the recurrence of disability. Explain why you believe your present condition is related to the original injury.
Doing paperwork at desk when back pain became severe. I was doing nothing different from usual day to day duties.

21. Describe all injuries and illnesses which you suffered between the date you returned to work following the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.
I have had no injuries and no illnesses since original injury.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to ob compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subjec civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be pun by a fine or imprisonment or both.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay and/or Compensation while disabled for wc

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish a desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representativ This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

22. Signature of employee	23. Date (mo., day, year)
John E. Jones	2-7-94

Figure 810-11. Form CA-2a--Recurrence of Disability.

Form CA-2a
Rev. Sept. 1

art B - Employer

ficial Supervisor's Report: Please complete information requested below

upervisor's Report

. Agency name and address of reporting office (include city, state, and zip code)

Human Resources Office - Code 0641
Naval Weapons Station
Yorktown, VA 23691-5000

OWCP Agency Code: 8888YY

Zip Code

OSHA Site Code

. Employee's duty station (Street address and zip code)

Same As Item 24

Zip Code

26. Date of first return to REGULAR duty following original injury. Mo. Day Yr. 12 13 94

. Regular work hours From: 7:30 [X] a.m. [ ] p.m. To: 4:00 [ ] a.m. [XX] p.m.

28. Regular work schedule [ ] Sun. [X] Mon. [X] Tues. [X] Wed. [X] Thurs. [X] Fri. [ ] Sat.

. Date of Injury Mo. Day Yr. 11 5 94

30. Date of recurrence Mo. Day Yr. 2 3 95

31. Date stopped work following recurrence Mo. Day Yr. 2 3 95 Time 10:15 [XX] a.m. [ ] p.m.

. Date pay stopped following recurrence Mo. Day Yr. Has Not

33. Date COP paid for recurrence From / To None

34. Date returned to work following recurrence Mo. Day Yr. Time : [ ] a.m. [ ] p.m. Has Not Returned

. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

Annual Leave	b. Sick Leave	c. Other (Specify)
	02-03-95 to Present	

. Pay Rate in Effect On:	a. Base pay	b. Subsistence	c. Quarters	d. Other Pay, i.e., Sunday premium or night differential
		None	None	None
. Date of Recurrence	$ 9.95 per Hr	$ per	$ per	$ per
. Date Stopped Work following Recurrence	$ 10.27 per Hr	$ per	$ per	$ per

7. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. [ ] Yes [X] No

38. At time of recurrence did official superior authorize medical treatment on form CA-16? [ ] Yes [X] No

9. Following the original injury, did the employer make any accomodations or adjustments in the employee's regular duties due to injury related limitation? If yes, provide full details. [X] Yes [ ] No

Employee was restricted to lifting no more than 20 lbs. He was assigned to input inventory data and answering telephone for 2 months.

0. Please review the statements provided by the employee in response to Part A of this form and provide all relevant comments and additional information.

I have reviewed the comments. I was aware that John continued to have back pain and used aspirin to relieve the pain.

. supervisor who knowingly certifies to any false statement, misrepresentation, concealment f fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

1. Signature of official superior (at time of recurrence)	42. Title	43. Official superior's work phone number	44. Date (mo., day, year)
Jerry A. Smith	Chief, B & B Section	(333) 444-6666	2-12-95

Form CA-2a Rev. Sept. 1993

Figure 810-11 Continued. CA-2a - Recurrence of Disability

Report of Termination of Disability and/or Payment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Part - A General

1. Name of Injured Employee (last, first, middle)	2. Social Security Number	3. OWCP File Number (If known)
SMITH, Sandra D.	101-01-1010	A06-08910
4. Department or Agency	**5. Bureau or Office**	
Defense Logistics Agency		

6. Name and Address of Reporting Office (Include Zip Code)

Defense Distribution Region East (Memphis), 2163 Airways Blvd. Memphis, TN 38114-5000

7. Date and Hour of Injury (Mo., day, year)	8. Date and Hour Stopped Work (Mo., day, year)	9. Date and Hour Pay Stopped (Mo., day, year)	10. Date and Hour Returned to Work (Mo., day, year)
1-12-95 11:00 [X] AM [ ] PM	1-12-95 11:00 [X] AM [ ] PM	N/A [ ] AM [ ] PM	06:30 1-18-95 [X] AM [ ] PM

11. Employee's Work Week On Return To Duty If Other Than Monday Through Friday

S M T W T F S

12. Present Pay Rate If Different From That Received At Time Employee Stopped Work.

a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)

13. Inclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of:

a. Annual Leave	b. Sick Leave	c. Other (Specify)
From: N/A Through:	From: N/A Through:	From: N/A Through:

14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury?

[X] Yes [ ] No If Yes, Describe The Type of Work Employee Is Performing.

Temporary restrictions on lifting (no more than 5 lbs) for 2 weeks, then resume normal duties.

15. If Interrupted, Show Dates Deductions For Health Benefits and/or Optional Insurance Were Resumed (Mo., day, year)

Health Benefit	Optional Insurance
N/A	

16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (Mo., day, year)

N/A

Number _____ Date _____

17. Remarks:

Part - B Continuation of Pay

18. Inclusive Dates That The Employee's Regular Pay Continued During The Period Of Disability. Do not include period of sick or annual leave (Mo., day, year)

From: 1-13-95 Through: 1-17-95

19. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received During The Period Of Disability. Do not include pay received for sick leave or annual leave.

3x8x9.66ph = $ 231.84

20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (Mo., day, year)

N/A

21. If Pay Rate Changed During The Period Employee Was Receiving Continuation of Pay, Give New Rate

a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)

22. Signature of Supervisor

John D. Smith

23. Title and Office Phone Number

Chief, Security Office
111-222-3333

24. Date (Mo., day, year)

January 21, 1995

Figure 810-12. CA-3 - Report of Termination of Disability.

Form CA-3
Rev. June 1988